Four Rivers Special Education District
936 W. Michigan Avenue
Jacksonville, IL 62650
Phone: (217) 245-7174
Fax: (217) 245-5533

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Student Name: ______________________________ Birthdate: _____________________________
Serving School: ____

I hereby authorize and request Four Rivers Special Education District to release to:

____

the following information:

___ Individual Education Program (IEP) ___ Social Development Study ___ Eligibility Determination Conference (EDC)
___ Medical History ___ Summary of Contacts ___ Full Case Study Components
___ Verbal Consultation ___ Psychological Report ___ Education Records
___ Other: ____

I understand that the consent granted by this written waiver is voluntary, and that I may withdraw this waiver at any time. I also understand that I have the right to inspect, copy and challenge such records in accordance with the Illinois School Student Records Act, 105 ILCS 10/1 et seq., and the Family Education Rights and Privacy Act, 20 U.S.C. §1283(g), and to limit any consent granted by this waiver to designated records.

____
Parent/Guardian/Adult Student (Age 18)

____
Relationship to Student

Release is valid until: __________________ Date/Time: __________________________

Four Rivers Special Education District
936 W. Michigan Avenue, Jacksonville, IL 62650
Phone: (217) 245-7174
Fax: (217) 245-5533

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

Student Name: ______________________________ Birthdate: _____________________________
Serving School: ____

I hereby authorize and request Four Rivers Special Education District to release to:

____

the following information:

___ Individual Education Program (IEP) ___ Social Development Study ___ Eligibility Determination Conference (EDC)
___ Medical History ___ Summary of Contacts ___ Full Case Study Components
___ Verbal Consultation ___ Psychological Report ___ Education Records
___ Other: ____

REQUESTED INFORMATION IS TO BE USED FOR COORDINATION OF SERVICES.

I further authorize and request:
____
____

To release to : Four Rivers Special Education District
936 West Michigan Avenue, Jacksonville, Illinois 62650
ATTN: ____

The following information:
___ Individual Education Program (IEP) ___ Social Development Study ___ Eligibility Determination Conference (EDC)
___ Medical History ___ Summary of Contacts ___ Full Case Study Components
___ Verbal Consultation ___ Psychological Report ___ Hospitalization Records
___ Other: ____
___ All Medical Records Including Psychiatric, Drug/Alcohol, and Related Records.

REQUESTED INFORMATION IS TO BE USED FOR PLANNING AND/OR COORDINATION OF EDUCATIONAL SERVICES.

I understand that the consent granted by this written waiver is voluntary, and that I may withdraw this waiver at any time. I also understand that I have the right to inspect, copy and challenge such records in accordance with the Illinois School Student Records Act, 105 ILCS 10/1 et seq., and the Family Education Rights and Privacy Act, 20 U.S.C. §1283(g), and to limit any consent granted by this waiver to designated records.

_____________________________________ _____________________________________
Student Signature (Age 12 or over) Parent/Guardian/Adult Student (Age 18)

_____________________________________ _____________________________________
Witness Date/Time Relationship to Student

Release is valid until: __________________ Date/Time: __________________________

4R-3 (a) 6/17